Authorization for Release of Medical Record Information

Patient Name: ______________________ DOB: _________________ Chart # ______________
Street Address: ____
City: ______________________________ State: ____________ Zip Code: ________________

Information to be released: (   ) From (   ) To : ______________________________
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(   ) From (   ) To : **Family Eye Care of the Carolinas**
1902 North Sandhills Blvd., Ste. E
Aberdeen, NC 28315
Fax: (800) 308-9356

- ❑ All Clinical Records
- ❑ Other Records – Please List (i.e. billing, photographs, etc.)

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Signature: ____ **Date:** _________________
(Parent or Legal Guardian of Minor)

This medical record ***may*** contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

- ❑ I consent to have the above information released.
- ❑ I **do not** consent to have the above information released.

Signature: ____ **Date:** _________________
(Parent or Legal Guardian of Minor)

I understand that this authorization is valid for a 1 year period from the date that is signed. I may revoke this consent at any time through written notice.

We strive to take every opportunity to safeguard patients' right to privacy. All patients have the right to expect that all communications and records pertaining to their care will be treated as confidential by any party entitles to review certain information in such records. We ask that all information transmitted be treated with utmost respect and the dignity such personal medical information warrants.

Enclosed are the reproduced medical documents specifically authorized by the patient or his/her legal representative. Any re-disclosure without the express written consent of the person to whom the information pertains is prohibited.

Thank you for your cooperation in maintaining the patients' right to privacy.